Pressure Reduction/Comfort Chair Assessment Form

| Name: |  | Sex: 🞏 M 🞏 F  | 🞏 Other:  |  | DOB: |  |
| --- | --- | --- | --- | --- | --- | --- |
| Address: |  | Phone No: |  |
| Clinician: |  | Agency: |  |
| People consulted: |  |

**MEDICAL HISTORY**

| Diagnosis/Prognosis: |  |
| --- | --- |
|  |
| Pain: |  |
| Height: |  | Weight: |  |  |
| Sensation: (note areas that are abnormal or insensate) |  |
|  |
| Skin History/Integrity: Intact Hx of Pressure Areas Red Areas Open Areas Scar Tissue |
| *(Refer to Braden Scale)* |  |
| Pressure Relief: Independent Assisted Dependent |
| Methods Used:  |  |
| Cushions: |  |
| Bladder Management: Continent Incontinent |  |
| Bowel Management: Continent Incontinent |  |

**SOCIAL HISTORY**

Environment (note space for chair, other furniture, floor surface etc.)

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| --- |
|  |
|  |

| Activity Configuration (note time spent in chair, activities to be done in chair etc) |
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|  |
|  |
|  |

**TRANSFERS/MOBILITY**

Transfer on and off chair:

Weight shifting in chair:

Does the client have significant contractures or extensor spasm:

Carer needs in assisting client:

**BASIC DIMENSIONS:**



| A | Seat - elbow: |  |
| --- | --- | --- |
| B | Back of knee - heel:  |  |
| C | Posterior of buttocks - back of knee: |  |
| D | Widest point at hips or thighs:  |  |
| Height: |  | Weight: |  |

**OPTIONS FOR CHAIR**

Customisation needed: Yes No Details:

Fabric preference: (vinyl, dartex, synergy, cloth, colour etc.)

Incontinence covers required: Yes No Seat belt required: Yes No

Armrest covers: Yes No Is the chair required for transport in Access Cab or a van: Yes No

**CARER/CLIENT GOALS and CONCERNS**

| Period of Use: |
| --- |
|  |

**ADDITIONAL NOTES/SUMMARY**

| Period of Use: |
| --- |
|  |
|  |
|  |
| Short term plan(s): | Trial Equipment: |  |
|  | Date/Place: |  |
|  | Obtain further information: |  |
|  | Other:  |  |

| Info given to client: | 🞏 Prescription agreement form: |  |
| --- | --- | --- |
|  | 🞏 “Preventing Pressure Sores” pamphlet  |  |

| **Clinician’s Name:** |  |  |  |
| --- | --- | --- | --- |
| **Clinician’s Signature:** |  | **Date:** |  |